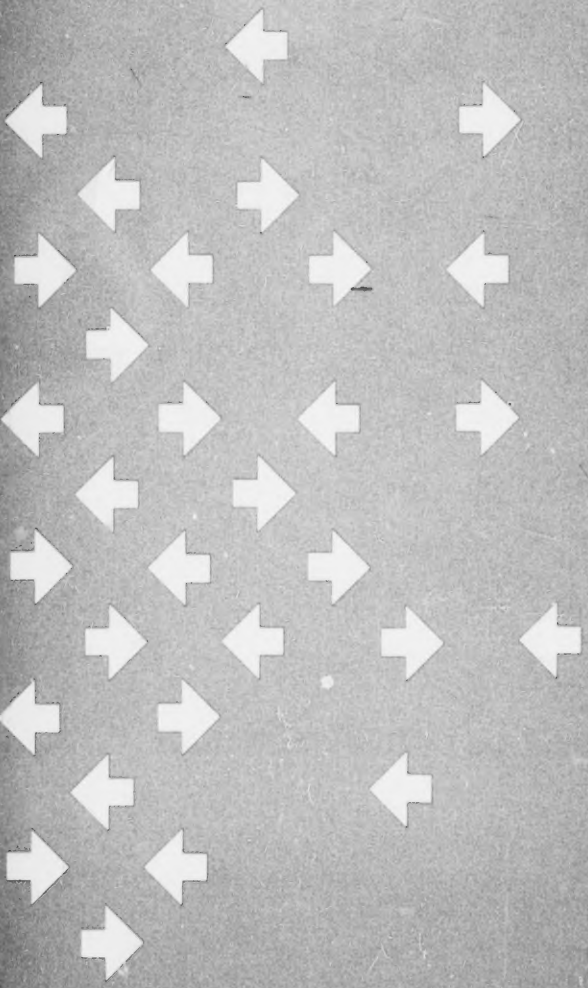
America in the 21st Century

SOCIAL AND ECONOMIC SUPPORT SYSTEMS



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PRB

America in the 21st Century

SOCIAL AND ECONOMIC SUPPORT SYSTEMS

Everyone from time to time needs a helping hand. For most Americans, the need for assistance is a temporary or transitional phenomenon — during childhood or old age, or after a short-term economic setback, such as the loss of a job or the destruction of a family home by fire or natural disaster. But for others, the effects of poverty or the presence of physical or mental disabilities may require long-term and multiple support arrangements.

The risk of dependency is generally associated with demographic characteristics — age, sex, race or ethnicity, geographic location, marital status, family composition, education, and income. Demographic changes, both now and in the future, will help determine who needs assistance and how that assistance is provided. Because many of our public policies to help people in need were designed during a time when different social, economic, and demographic circumstances prevailed, we need to reassess how best to respond to current and future challenges.

This report is part of a series of publications on "America in the 21st Century" prepared by the Population Reference Bureau under a grant from the Ford Foundation. The series highlights the importance of demographic change in shaping our local communities and world environment as we enter the next century. Other reports in the series include:

- A Demographic Overview
- Human Resource Development
- Infrastructure Needs
- Environmental Concerns
- Governance and Politics
- A Global Perspective

Together, these reports cover a broad range of issues and important public policy topics. They are designed to inform the reader about the interaction between demographic trends and public policy considerations and to challenge our thinking about the kind of world we are likely to face as we enter the 21st century.

HELPING THOSE IN NEED

As Americans entered the 1990s, public opinion polls generally found them satisfied with their personal well-being, although cautious and even pessimistic about the future. Over three-quarters of the respondents to a Gallup poll said that they anticipated the overall quality of their life to improve by the year 2000, but a greater number (80 percent) said that it would be harder to buy a house, pay for college tuition, or afford the costs of retirement or medical care in the future. Such concerns have made even sanguine middle-class families feel a need for assistance in order to achieve the American dream. Meanwhile, a growing number of Americans are slipping into an emerging underclass defined by persistent poverty and deteriorating urban neighborhoods. Homelessness, substance abuse, teenage pregnancy, crime, violence, and structural unemployment have focused a spotlight on issues of poverty and people in need. Because rapid social, economic, demographic, and technological changes have altered the institutional foundations of society, we need to reexamine our social and economic systems of support that help people in need.

The ability to cope with hardship varies throughout the life cycle. Children are dependent on adults to provide them with economic security and a sense of social and physical well-being. The elderly may have personal and financial resources to help them during difficult times, but they generally are less able than working adults to rebound after a prolonged illness or catastrophic mishap. For others — most notably the working poor — structural changes in the U.S. economy have left them vulnerable to periods of unemployment or underemployment.

Helping those in need and providing them with the means to achieve self-sufficiency can be a complex and often difficult process. The U.S. social welfare system is a patchwork of programs in which responsibility is divided between various levels of government and types of service providers. The family functions as the first and foremost source of support, but religious and nonprofit service organizations, as well as government programs, serve as backup systems to strengthen the family's capacity to assist those in need. Social and demographic changes, however, are altering the basic structure of the support network and could increase the number of people who will need assistance in the 21st century.

- **Families are changing.** Just over one-third of first marriages now remain intact for life. Fewer than one in eight families now consists of a married couple with children in which the mother does not work outside the home. Today, more than half of all women with a child under age six are in the paid labor force. Over 6 million households with young children are headed by a single parent, and this number could increase to 7.5 million by 2000 under current trends. Time constraints, competing pressures, and marital dissolution are undercutting the family's ability to perform its role as the mainstay of assistance to dependent family members.

▲ With two parents working outside the home, family life faces new challenges.

- **Life expectancy has increased and more people are surviving to older ages.** When the Social Security Act was passed in 1935, life expectancy in the U.S. was just below 62 years. Now, it hovers around 75 years and shows continued signs of improvement. By 2030, one in five Americans will be age 65 or older, compared to just one in eight today. And the number of people age 85 or older is expected to triple by 2030, accounting for more than 8.6 million people. Nearly half of today's 20-year olds can expect to reach age 80, compared to less than one in four in the 1930s. The increasing number of older Americans will put a significant strain on the nation's health-care services and retirement-income programs in the years ahead.

- **Racial and ethnic diversity is increasing.** Birth rates of the non-Hispanic white population have been at or below replacement level for the past 25 years. Meanwhile, immigration from abroad and higher fertility rates among blacks and some Asian and Hispanic groups are creating greater racial and ethnic diversity in the population. While people of color currently account for 24 percent of the U.S. population, this proportion is expected to grow to over 30 percent by 2030. As minorities become a larger share of the population and of the labor force, their special needs and problems will begin to impact more directly on the support systems and economic structures of U.S. society. Minorities today are more likely than their white counterparts to have lower levels of education, fewer job skills, and to be poor. If these patterns persist, they could affect not only the number of people in need of assistance, but also the productivity and future economic competitiveness of the nation.

- **The income gap between the rich and the poor is widening.** In 1969, families in the top 20 percent of the nation's income distribution accounted for 41 percent of all income; by 1989, they held 45 percent. Meanwhile, families at the bottom 20 percent of the income scale lost ground, declining from 5.6 percent to 4.6 percent. Middle-income families also held a smaller share of national income by 1989. One-fifth of the nation's children currently live below the U.S. poverty line, and 8.8 million young adults (ages 18 to 34) in 1987 were in poverty—a 50 percent increase over 1977 levels. Economic polarization is affecting the number and composition of people who are poor, and raising questions about the vitality of America's middle class as well as social and economic prospects for our youth.

- **State and regional differences affect our ability to help people in need.** During the 1960s, '70s, and '80s, the U.S. population shifted from the Northeast and Midwest to the South and West. Growth in the sunbelt states was also spurred by the influx of immigrants. Over 40 percent of new immigrants during the 1980s settled in just three states—California, Texas, and Florida. While most central cities in the Northeast and Midwest lost population during the 1980s, the surrounding outer suburbs appeared to grow exponentially. New and growing residential areas are often attractive to young adults who are well-educated and have high earnings potential. Left behind are some of the neediest and most vulnerable population groups. Such patterns only widen the breach between those who need supportive services and the community's capacity to pay for and staff them.

Addressing the needs of dependent populations both now and in the century ahead will require a better understanding of the realities of demographic change. This report looks at several of the most vulnerable populations in the U.S.—children at risk, families in need, the frail elderly, and persons with disabilities.

CHILDREN AT RISK

Today's children represent the workers and parents of the 21st century. Children who began grade school in 1988 will be the high school graduates in the year 2000. A child born today is likely to marry around the year 2015 if current marriage patterns hold; and about one in 10 will start a family before 2010 if current patterns of teenage childbearing continue. The education, economic security, and social stability that children receive today are a critical measure of the nation's future.

By many measures, U.S. children face a life that is healthier and more promising than at any time in the past. But a substantial number of children remain at risk of living in poverty, dropping out of school, and engaging in socially dysfunctional behaviors. Because birth rates have dropped dramatically since the 1960s and remain at fairly low levels, there are relatively fewer children now than in years past. This makes our investment in the well-being of each child all the more critical.

Health Care in the Early Years

Demographic statistics show that many children in the U.S. begin life on relatively shaky ground. Nearly 7 percent of all children born in 1988 were considered low birth weight — that is, they weighed less than 5.5 pounds — and black infants were twice as likely as white infants to be low birth weight. Because birth weight is the best predictor of a child's chances of survival in the first few weeks of life, the prevalence of low birth weight infants is one of the earliest and most critical indicators of a child's well-being. Low birth weight infants, for example, if they survive, are at greater risk of long-term health problems ranging from neuro-developmental disabilities to lower respiratory tract conditions such as asthma. About one-quarter of all low birth weight infants born in 1988 (or 67,000 children) will enter the next century with a permanent, disabling condition.

Table 1.
INFANT MORTALITY RATES IN DEVELOPED NATIONS: 1988

Rank	Country	Infant Mortality Rate
1	Japan	4.8
2	Sweden	5.8
3	Finland	6.2*
4	Switzerland	6.8
5	Canada	7.2
6	West Germany	7.5
7	Netherlands	7.6
8	France	7.7
9	Denmark	7.8
10	Austria	8.1
	East Germany	8.1
12	Norway	8.4
13	Spain	9.0*
	United Kingdom	9.0
15	Australia	9.2
	Belgium	9.2
17	Ireland	9.3
18	Italy	9.6
19	**United States**	**10.0**
	New Zealand	10.0*
21	Greece	11.0
22	Czechoslovakia	11.9
23	Portugal	13.1
24	Bulgaria	13.6
25	Hungary	15.8
26	Poland	16.2
27	U.S.S.R.	24.6
28	Romania	25.6**
29	Albania	28.2*

Infant mortality rate is the number of deaths in the first 12 months of life per 1,000 live births.

**1987 rate.*

***1985 rate.*

SOURCE: United Nations and country publications.

What is more, the medical costs associated with the care of low birth weight infants can be staggering. Neonatal intensive care services in 1987 ranged from $14,000 to $30,000 for initial hospitalization, according to the U.S Office of Technology Assessment, and long-term care services and health care for a child with a permanent disability can mount to $100,000 annually.

Yet despite advances in medical technology that can increase an infant's chances of survival, the U.S. ranks 19th among developed nations in terms of infant mortality (see table 1). Southern states

tend to have the highest rates of infant deaths (see state data table p. 26). But even among states with the lowest infant mortality rates, there are wide differences by mother's race or ethnicity and by geographic regions within a state.

The risks of low birth weight and infant deaths are closely linked to the socioeconomic and demographic characteristics of the mother and her access to health care. Babies born to women who are younger than age 20 or older than 34, who are minority, unmarried, poorly educated, or living in poverty are at greatest risk of being low birth weight or of dying. Indeed, the problem is particularly acute in the black community. In 1988, for example:

- Infant mortality rates among blacks were twice as high as among whites (18 per 1,000 births versus 9 per 1,000 births, respectively). Infant mortality for Hispanics was 8 per 1,000, but this figure may understate actual rates because of reporting problems.

Low birth weight infants have a high risk of developing a permanent disabling condition.

- Proportionately twice as many black babies (13 percent) as white or Hispanic babies (6 percent, each) were low birth weight.
- The percentage of mothers who received late or no prenatal care was three times as high for Hispanics (12 percent) and blacks (11 percent) as for whites (4 percent).
- The percentage of infants born to unmarried mothers was more than three times higher for black women (63 percent) as for whites (18 percent) and almost double the rate for Hispanics (34 percent).

A key element to addressing these problems is improving access to medical care for pregnant women and young children. Research has shown that for every $1.00 spent on prenatal care for low-income and poorly educated women, $4.40 could be saved during the first year of an infant's life in child health services. Some experts estimate that as many as one in 10 infant deaths could be prevented by early medical intervention and better prenatal care. New federal regulations extending Medicaid coverage to all pregnant women who meet AFDC income and resource requirements and all children under age 18 may help to ease the problem, but states question how they will pay for these additional services without additional federal funds. Currently about 35 percent of female-headed, low-income families do not receive Medicaid benefits.

Teenage Pregnancy

In 1988, 500 babies were born each day to girls under the age of 18. More than 1 million girls under the age of 20 – or one in 10 teenage girls – became pregnant. Just under half of these young women gave birth; the others ended their pregnancies by abortion or miscarriage. Approximately 30 to 40 percent of teens who become pregnant will conceive again within two years. Demographic trends and changing social attitudes have affected U.S. patterns of adolescent pregnancy and childbearing.

▲ One in ten teenage girls becomes pregnant each year.

Both the number of births to teens and the rate of teenage childbearing have decreased substantially since 1970, but the proportion of teens who are sexually active and become pregnant each year has risen. In 1988, 488,900 babies were born to teenage mothers, down from 656,500 in 1970. Birth rates for teens (ages 15 to 19) also dropped from 69.3 to 53.6 during this period. Most of the decline in the number of births is due to the drop in the number of teens in the population as the baby boom generation moved out of its teenage years. But some of the decline can also be attributed to the legalization of abortion in 1973.

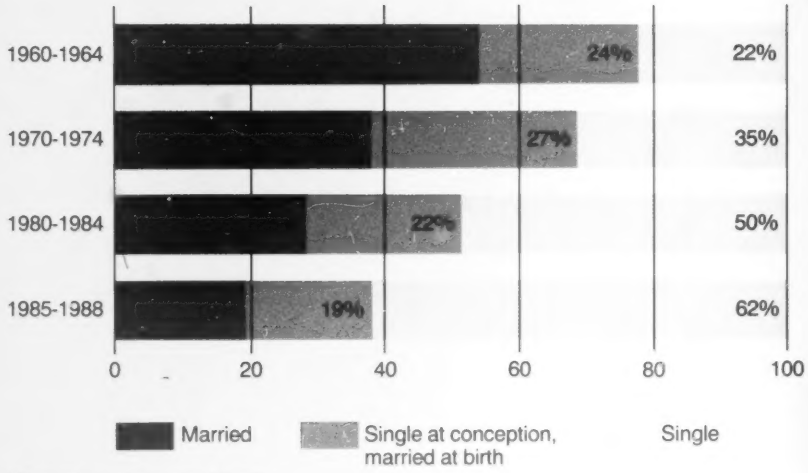
Adolescent sexual activity, however, has increased. In 1971, about three of every 10 teenage girls were sexually active. Now, four of every five have had sexual intercourse by age 19. Among young men, recent surveys show that 86 percent of non-black males and nearly all black males have had intercourse by age 19.

Although the levels of sexual activity among American youth is comparable to those of other industrialized countries, the U.S. has higher rates of teenage pregnancy. About one in 10 young American women (ages 15 to 19) gets pregnant each year – a rate that has remained fairly constant throughout the 1980s. Research repeatedly finds that U.S. teens are slow to adopt contraception. Many adolescents delay seeking contraceptive advice or services because they think they will not get pregnant "just-this-once" or because they view health clinics as impersonal, unsanitary, or lacking confidentiality. However, more than half of premarital pregnancies occur during the first six months of exposure to intercourse. Some recent survey data show an increase in condom use among teens, but it is too early to know if this will lower pregnancy rates.

What these data suggest, however, is that U.S. teens are taking tremendous risks with their reproductive health and with their futures. Many teens drop out of school once they are pregnant, although a recent study has shown that over half (58 percent) eventually complete their high school education by their mid-20s. Even so, women who bear children in their teens are less likely to complete college than those who delay childbearing, and they are more likely to suffer long-term economic consequences because of their lower skill levels. Nearly half (46 percent) of teenage mothers go on welfare within four years of giving birth, although the majority (76 percent)

Figure 1.

MARITAL STATUS OF TEEN MOTHERS AT FIRST BIRTH: 1960 TO 1988



**Births to women age 15-19.*

SOURCE: U.S. Bureau of the Census.

leave the welfare rolls within four years of first receiving public assistance. Teens, like other age groups in the population, are delaying marriage, and over half of all teenage births today occur outside of marriage — almost three times the rate of the early 1960s (see figure 1).

Contrary to popular belief, teenage childbearing is not just a problem for minorities. In fact, minority youth do not account for the majority of teenage births. About two-thirds of teenage births are to white teens. But minority teens are at greater risk of early parenthood and particularly of being unmarried parents. About 90 percent of the births to black teens and 57 percent of the births to Hispanic teens occurred to unmarried mothers, compared to 49 percent of the births to white teens. By the time they are 18 years old, 7 percent of whites, but 14 percent of Hispanics and 26 percent of blacks, have given birth. These differences are not because minority youth are more sexually active. Instead, they reflect lower use of contraception and abortion among minority teens.

Helping teens understand and handle their emerging sexuality will be both a family and societal issue in the coming decades. The costs of adolescent childbearing to society can be high. The Center for Population Options calculated that in 1989 the federal government alone spent $22 billion in Aid to Families with Dependent Children (AFDC), Medicaid, and food stamps to support families that began when the mothers were teenagers. Add to this figure the costs of lost economic productivity to the nation and the wasted opportunity to build self-esteem and self-sufficiency among a large segment of youth, and the social and economic costs of adolescent pregnancy grow.

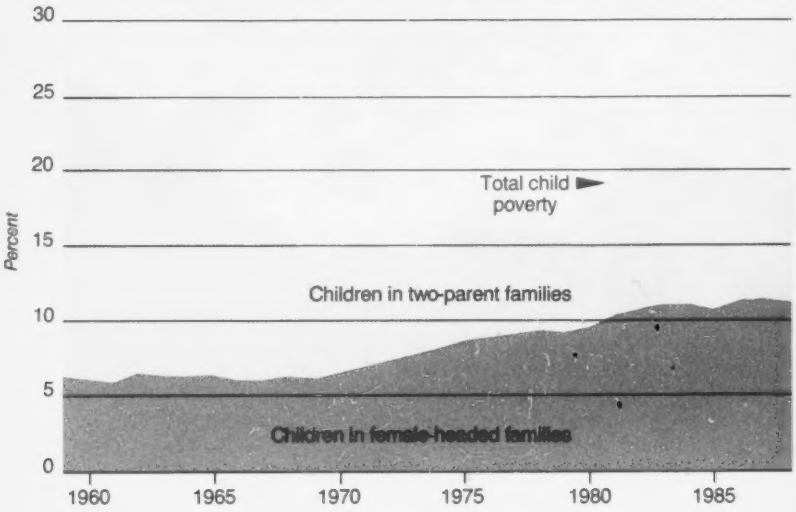
But there may also be a hidden cost that we have yet to see and measure fully. The risks of sexually transmitted disease, particularly AIDS, has grown in recent years. Nearly one in five AIDS patients in the U.S. are people in their twenties, and by October 1990, 600 cases of AIDS among teenagers had been reported to the Centers for Disease Control. Since it can take as many as seven years for the HIV virus that causes AIDS to appear, many young adults probably contracted AIDS during their teenage years. The need for information and services to help teens make informed choices will therefore be a major public policy challenge for the 1990s. Whether dissemination of information comes from parental and religious guidance, family life courses in the school curriculum, or school-based clinics is less important than the need for teens to learn and know the facts about sex, sexuality, and the social, economic, and health consequences of their actions.

FAMILIES IN NEED

In the mid-1960s, the federal government created an official poverty index to help determine who was in need of assistance. Except for annual adjustments for inflation, this measure has been virtually unchanged over the years and remains the standard for determining poverty in America. The index is based on the U.S. Department of Agriculture's 1961 Economy Food Plan — a measure of food consumption at which a family can maintain a minimally adequate diet. Economists at that time found that a family of three spent about one-third of its income on food, so the poverty line was set at three times the cost of the Economy Food Plan. The index is scaled to account for variations in

family size, but not for regional differences in the cost of living. In 1989, the poverty threshold for a family of four was $12,700; for a person living alone, $6,300; and for a family of nine or more persons, $25,500. Median income for a family of four in 1989 was $40,800.

Figure 2.
CHILDREN IN POVERTY BY FAMILY STATUS: 1959 TO 1988



SOURCE: U.S. Bureau of the Census.

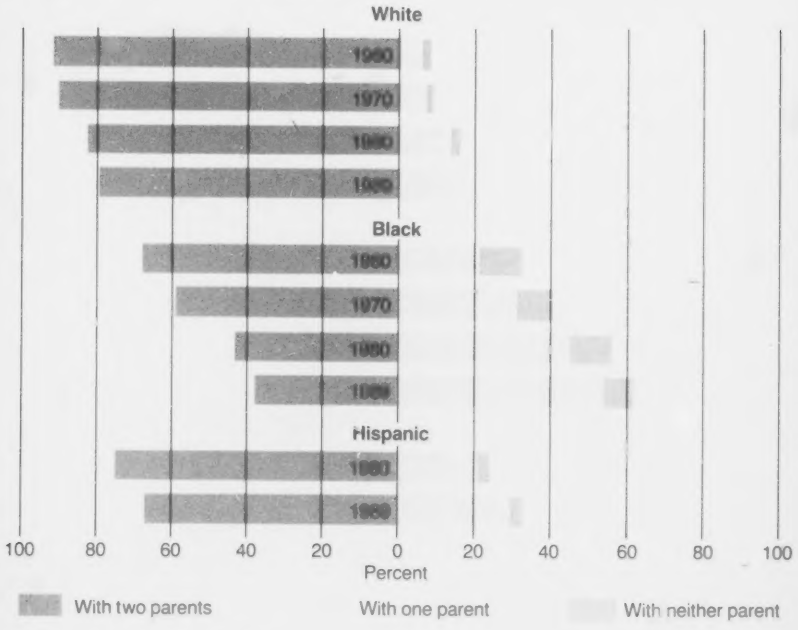
While there has been almost no change in how the poverty line is drawn, there has been considerable change in the demographic composition of the poverty population. Elderly persons once had the highest rates of poverty — one in three were classified as poor in 1959. Now, persons living in female-headed households and persons living alone (many of them elderly) are at greatest risk of being poor. Today, 11 percent of the elderly live in poverty, but 20 percent of children are poor. The gradual rise in mother-only families has meant a steady increase in the proportion of children who live in poverty. But the dramatic swings over time in poverty rates for children are linked to the economic well-being of two-parent families (see figure 2).

Single Parent Families

Today, 24 percent of all children under age 19 (or 15.2 million children) live with just one parent – double the percentage of 1970 and almost triple that of 1960. Higher divorce rates since 1960 and more out-of-wedlock childbearing have resulted in

Figure 3.

LIVING ARRANGEMENTS OF CHILDREN UNDER 18 YEARS: 1960 TO 1989



SOURCE: U.S. Bureau of the Census.

greater numbers of children living in single-parent homes. Demographers estimate that at least half of all children born today will spend some part of their childhood with only one parent – usually the mother. Just one-third (36 percent) of these children will become part of a stepfamily within five years of their parents' divorce, and even then, about half will also see their new family dissolve. The majority of children whose parents divorce are likely to spend their childhood in single-parent homes.

Minority children are at greater risk of living in single-parent families than are white children (see figure 3). In 1989, over half of all black children and 30 percent of Hispanic children lived with just one parent, compared to 19 percent of white children. Single-parenting is the result not only of failed marriages, but also of more out-of-wedlock births. Sixty-two percent of all black infants, 26 percent of Hispanic infants, and 18 percent of white infants in 1988 were born to unmarried mothers. Interestingly, one-quarter of all out-of-wedlock births are to two-parent (though unmarried) households.

Although the effects of marital disruption and single-parenting on the social and emotional development of children are not well understood, the economic consequences are quite clear. Over half (52 percent) of the children in female-headed households are poor, compared to 9 percent of children in married-couple households. The feminization of poverty has had dire consequences for children, and demographic trends suggest a further expansion of the problem. The U.S. Bureau of the Census has projected a 25 percent increase in the number of female-headed households between 1985 and 2000 — a situation that is likely to add more children to the poverty rolls.

Children are most at risk of being poor; one in five currently lives in poverty.

Most single mothers work, but their earnings often do not lift their families out of poverty. Median family income in 1989 for a single-mother with children was $13,000. Moreover, absent fathers play almost no role in the financial support of their children. National survey data show that over 60 percent of absent fathers pay no child support, and only 6 percent contribute more than $5,000 a year to their child's support. Welfare payments, including AFDC, food stamps, and Medicaid, are not sufficient in any state to keep a family out of poverty.

Efforts at welfare reform have emphasized work and self-sufficiency for single mothers, but about one-third of AFDC mothers have less than a high school education and have not worked in the last five years. It is hard to imagine that these women will be able to find jobs that will lift them out of poverty unless they receive intensive education in basic skills and job training. Some states, such as Massachusetts and California, have instituted comprehensive work-welfare programs, combining job training, job counseling, child care, and other supportive services for welfare mothers. While these programs have posted some success, critics charge that such measures are too costly and succeed only within a healthy and booming economy.

On the other hand, a few states, notably Wisconsin and New York, are experimenting with more uniform systems of child support payments, coupled with aggressive collection efforts. One proposal is to set a mimimum standard of child support for absent parents and to collect payment through automatic payroll deductions. If the absent parent is unemployed or has wages that are too low to meet the minimum standard, then the state would make up the difference. Implementing such a plan is sure to meet resistance from employers and absent parents, but many custodial parents would benefit from a regular and predictable system of child support payments.

Working but Poor

The struggle to provide a decent standard of living for one's children is not limited to single-parent homes. Nearly 2 million married-couples with children were living below the official poverty line in 1989. Another 2 million reported income just above the poverty mark (that is, within 150 percent of poverty).

For most Americans, the vast majority of their income comes from their employment. But increasingly, the traditional assumption that holding a job will keep an individual out of poverty no longer seems to apply. In 1989, 42 percent of all people age 18 or older with incomes below the official poverty line worked at least part of the year. Of those who worked, nearly one-quarter worked full-time, year-round. Fifty-nine percent of the 6.8 million families living in poverty in 1989 had at least one worker and 19 percent had two or more workers.

Structural changes in the U.S. economy are making it more difficult for families and individuals to make ends meet. One of every six U.S. workers (or 20 million people) is now employed in a part-time, year-round position. Another 760,000 workers hold temporary jobs at any given time throughout the year. Indeed, part-time and temporary work has been the fastest growing segment of the labor market. Since 1980, part-time employment has risen 20 percent, and the number of temporary workers has almost tripled. Many people want part-time jobs, but for those who must raise a family or have no other means of support, part-time or temporary employment may offer limited security and unsteady wages. Not all part-time or temporary jobs are low-skilled or low-paying, but they generally do

not offer fringe benefits, such as health insurance or paid sick leave. Indeed, nearly 20 percent of the nonelderly population who lacked health insurance coverage in 1986 were in families headed by a part-time or part-year worker.

Families have responded to changing economic conditions in at least two ways: by having fewer children and by having more mothers in the labor force. Whereas the average family size in 1960 was 3.7 persons per household, now it is 3.2. Labor force participation rates for women rose from 35 percent in 1960 to 57 percent in 1990. Even the number of working mothers with young children has soared. In 1975, fewer than one in three women with a child under age one worked outside the home; now more than half are in the paid labor force. While there may be fewer children at home, many families – both dual-income and single-parents – are finding that there is less time to attend to their children's needs.

Economic setbacks and structural unemployment have increased the number of families in need of assistance.

Young families, in particular, seem to be struggling to get by. According to Harvard researchers Mary Jo Bane and David Ellwood, the increasing number of children in poverty during the 1980s reflected in part the continued stagnation in men's wages. The median income of full-time, year-round male workers is lower today than it was in 1973. A full-time job paying 1991 minimum wage rates of $4.25 an hour falls $3,800 short of reaching the current poverty line for a family of four.

With federal government policies hampered by budget deficits and a reluctance to raise taxes, most strategies for helping families tend to focus on the business community. Flexible compensation programs and a restructuring of benefits are seen as ways of helping families meet their needs. Demands for a higher minimum wage, child care assistance, flexible work arrangements, parental leave, and expanded health insurance coverage reflect the changing composition of the work force and changing family structures. Businesses argue that mandating such benefits would impose too much cost and make them less competitive. Some analysts feel that these policies are simply new forms of middle-class entitlements that will not help the truly needy. But the realities of demographic change suggest that families at all income levels may be in need of some assistance and flexible support arrangements.

Retired Seniors

The growth of Social Security and private pensions have made it possible for many older persons to maintain a standard of living in retirement that is relatively comparable to what they enjoyed during their working years. Today, over 90 percent of all persons age 65 or older receive Social Security benefits and over half receive private pension income. Whereas the elderly once had the highest rates of poverty, they now have the lowest. But while today's older population is certainly better-off financially than previous generations, specific pockets of poverty remain closely tied to demographic factors.

- Poverty rates within the older population increase dramatically with age. In 1989, about one in 10 persons age 65 to 74 was living in poverty, but almost one in five (18 percent) of those age 85 and older was poor. The number of elderly who will be 85 or older is expected to triple by the year 2030.

▲ **Minorities will account for a greater share of the older population in the years ahead.**

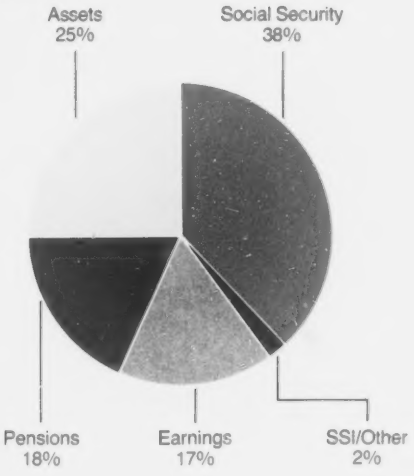
- Similarly, the rates of poverty for minority elderly are two to three times higher than for the white population. Nine percent of white elderly lived in poverty in 1989, compared with 21 percent of Hispanic elderly and 31 percent of black elderly. Racial and ethnic minorities are fast becoming a larger share of the U.S. population, and are expected to account for one-third of the population by 2030.

- And because women tend to outlive men, marital status and living arrangements play an important mediating role in determining poverty status. Older widows and unmarried women who live alone are three to four times more likely than their married peers to live in poverty. Continued improvements in life expectancy, particularly for women, and changing marriage, divorce, and remarriage patterns put a substantial number of today's women at risk of spending some portion of their older years in poverty if current rates prevail.

Financial security in old age to a large extent depends on past patterns of work, savings, and investments. Typically, Social Security represents the largest share of an older person's income (38 percent), with assets the second largest source. Pensions and earnings from paid employment contribute almost equal shares (see figure 4).

Figure 4.

INCOME OF POPULATION AGE 65 AND OLDER BY SOURCE: 1988



SOURCE: U.S. Bureau of the Census.

However, because women and minorities are more likely than white men to have had numerous periods of unemployment, part-time employment, or to have held low-paying jobs, their average Social Security benefit is generally smaller and their ability to accumulate pensions much less. In such situations, Social Security benefits generally represent a larger share of total income. Indeed, for many low-income elderly, Social Security payments can represent almost all of their retirement income.

With the proportion of retirees to workers rising, concern has grown about society's ability to meet future Social Security obligations. Today, there are roughly five people of working age (ages 18 to 64) for every person age 65 or older. By 2030, however, the ratio will be three to one. The aging of the post-World War II baby boom generation will set off a "senior boom" in the early years of the 21st century. By 2020, about 51 million Americans will be age 65 or older, compared to just under 30 million today. While long-range (75 year) forecasts by Social Security actuaries show that the system is financially sound and currently accumulating a large reserve of funds, federal budget deficits and rising health care costs pose significant threats to maintaining the program on its current course.

Some analysts look to the growth in private pensions as another means of funding future retirement income. Since 1974, the number of plans has more than doubled from 340,000 to over 870,000. Nearly 60 percent of today's workers are eligible to participate in an employer-sponsored pension plan, although only half have enough years of service to be fully vested in a plan and therefore entitled to future benefits.

Pension coverage varies signficantly by size of firm and industry. Large private firms, state and local governments, and manufacturing industries have the highest rates of coverage, while small firms and some service industries often lack pension plans. What is troubling to some analysts is that recent job growth has been precisely in the areas where pension coverage is weakest, namely small businesses and service sector jobs. Indeed, during the 1980s, both the proportion of employers who sponsored a pension plan and the percentage of workers who participate in a plan declined. But the growth of alternative retirement plans, such as the individual retirement accounts (IRAs) or 401(k)-type salary deferral arrangements, may somewhat offset the observed decline in pension programs. Also, some workers who currently lack coverage may have an opportunity to participate in a pension plan at a future time.

Nonetheless, important public policy questions have been raised about private pensions and their impact on the nation's economy. Do vesting requirements, for example, reduce worker turnover or impede flexibility? As private pensions are made more cash portable to accommodate the numerous job and career changes that today's worker is likely to make in his or her lifetime, will these cash distributions be preserved for retirement or spent on current needs? Will the movement toward defined contribution plans, rather than defined benefit plans, provide future retirees with an adequate stream of income in their later years? Because private pensions represent the greatest accumulation of savings for low- and middle-income workers and greatly influence the performance of financial markets, policy makers will need to monitor carefully public and private employer pension plans to formulate effective strategies to meet the retirement income needs of the baby boom generation.

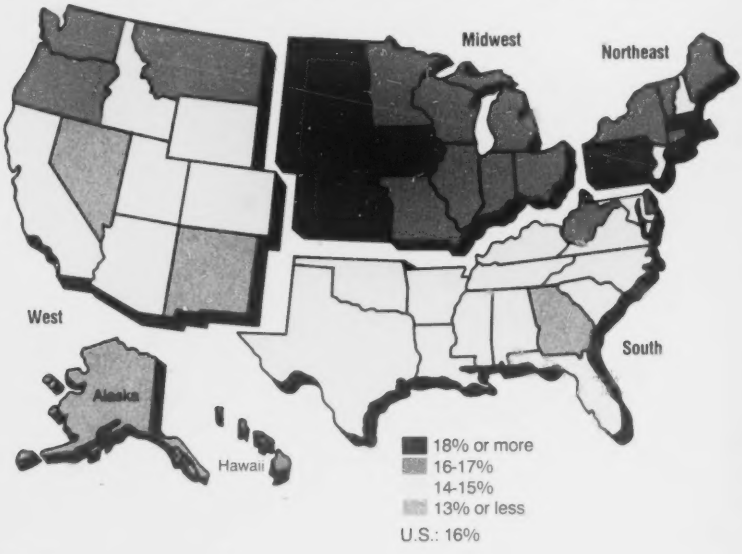
FRAIL ELDERLY AND PERSONS WITH DISABILITIES

Perhaps nothing illustrates the strengths and weaknesses of our social and economic support system more than the way we care for our older and disabled populations. It is an intricate mixture of public and private supports, a complicated patchwork of programs and services, and a system pressed by demographic change and rising costs. The tremendous gains in life expectancy throughout this past century have created a new social phenomenon for the next century – the care and support of an unprecedented number of older persons. Early intervention and diagnosis of illness, technological advances, and improved access to health care services are increasing the life span of many individuals. Even persons with disabilities who, in the past, had severely limited life expectancies are now living relatively normal life spans. About one in four persons with Down Syndrome (the most common cause of mental retardation) now lives to at least age 50, and significant numbers are living into their 70s.

Family members typically serve as the traditional caregivers for persons with disabilities, but as the population ages, the caregivers themselves grow older and may require supportive services. This is a problem not only for older persons but also for the parents and siblings of persons with mental retardation and other developmental disabilities. As a result, the fields of gerontology and disabilities share similar concerns and have begun to work more closely to develop systems of care that will meet a growing need.

Figure 5.

PERCENTAGE OF ELDERLY (AGE 65+) WHO WILL BE AGE 85 OR OLDER: 2010



SOURCE: U.S. Bureau of the Census.

The Need for Support

While the majority of older people lead relatively healthy and independent lives, the risk of becoming functionally disabled and in need of assistance increases rapidly with age. Among those who live in the community, only one in seven persons age 65 to 69 reports having a disabling condition (such as the need for assistance in eating, bathing, dressing, walking, or using the toilet), but one in two persons age 85 or older is functionally disabled. Currently, an estimated 6.8 million people age 65 or older have a condition that limits their ability to carry on the everyday tasks of life. Projections show that this number could increase to 9 million by 2000 and to 18 million by 2040. Growth among the population age 85 and older – the most vulnerable segment of elders – is expected to almost double within the next 20 years, reaching 6.1 million people by 2010. In Iowa, for example, 20 percent of the state's senior population (age 65 and older) will be comprised of individuals age 85 and older. The Northeast and Midwest will have particularly large concentrations of the very old among their senior populations (see figure 5).

While the popular image is that most older persons move to the sunbelt states upon retirement, the demographic reality is that only 5 percent of the elderly change their residence in any given year. Most older people age-in-place, that is, they remain in the community in which they spent most of their adult life. This has important implications for service delivery programs because the majority of older persons now live in suburbs, rather than in inner-city neighborhoods. Reaching this population becomes logistically more difficult because service providers must spread their services across a wider and more scattered area than before.

Caregiving Arrangements

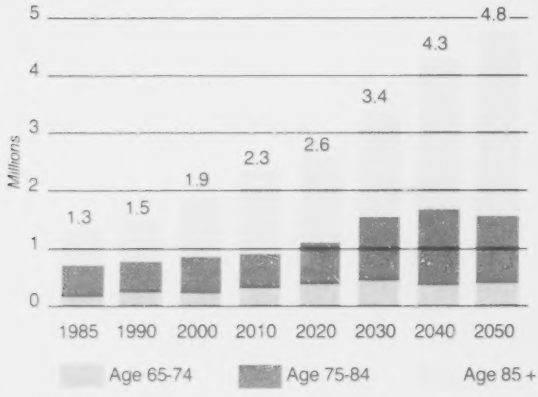
For the frail elderly and for persons of any age with functional disabilities, the family serves as the main source of support and assistance in carrying out tasks of daily living — preparing meals, running errands, assisting with personal hygiene. Over 90 percent of older disabled people who live in the community rely, at least in part, on family and friends for care; 80 percent do so exclusively. Seeking professional assistance is generally regarded as a last resort. Even then, community-based services, rather than institutional care in a hospital or nursing home, is the preferred arrangement. Only 5 percent of elderly live in nursing homes at any given time, but the odds are roughly two in five that a person age 65 will spend some time in a nursing home before dying.

For elderly married couples, the spouse generally serves as the primary caregiver. But since less than 40 percent of women over the age of 65 are married, supportive care for older women usually comes from an adult child — most often a daughter or daughter-in-law. Demographic trends, however, are creating signficant tension in this arrangement. Women's increased labor force participation leaves less time for family caregiving. Forty-four percent of adult daughters (or daughters-in-law) who care for an impaired parent are employed, according to findings from a national survey on long-term care. Twelve percent reported that they had quit their job in order to provide care. Nearly one-quarter of the caregiving daughters or daughters-in-law in the study reported at least one child under the age of 18 still living at home.

From a policy perspective, unpaid family caregivers may help lower the public costs of long-term care, but the arrangement also robs the economy of a fully productive work force. This trade-off may be even more striking in the future as labor markets tighten and the baby boom generation with its relatively low fertility has fewer children to care for them in their older years.

Figure 6.

NURSING HOME POPULATION AGE 65 AND OLDER: 1985 TO 2050



SOURCE: U.S. Administration on Aging.

Projections of the nursing home population, based on current rates of use, forecast very rapid increases, rising from 1.5 million to 1.9 million by the year 2000 and then more than doubling to 4.8 million by 2050 (see figure 6). More than half of nursing home residents are expected to be age 85 or older. The vast majority will be women.

Ability to Pay

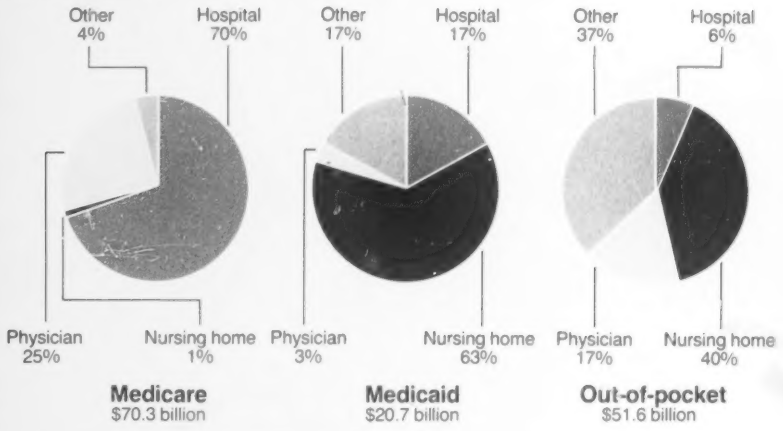
Although persons age 65 and older represent 12 percent of the population, they account for over 35 percent of health care costs. Per capita spending on health care for the elderly reached $5,770 in 1988 — a 10 percent average annual increase from 1977. Medicare and Medicaid pay roughly 60 percent of the costs, with private payers (both individuals and insurance programs) paying the remaining 40 percent. Total health care expenditures for the elderly amounted to $175 billion in 1988.

With health costs rising, many older people are hard pressed to pay for the medical care they need. The Medicare program, which pays the largest share of health care costs for the elderly, is structured to pay primarily for hospital-based, acute care (see figure 7). Long-term care expenses, such as nursing home care, are paid primarily by individuals and (for the poor) by Medicaid. Most older persons enter nursing homes as private paying patients, but with nursing home costs ranging from $20,000 to $40,000 per year, their personal resources are quickly consumed. Almost one-quarter of older people who enter nursing homes as private pay patients deplete their savings and convert to Medicaid payment. The average length of stay for nursing home residents is difficult to measure because of repeated discharges and readmissions, but approximately one in five residents stays five years or more.

With the inevitable aging of the population, policy makers are faced with twin challenges – how to lower the escalating cost of medical care and how to pay for services. Current cost containment strategies have been relatively ineffectual. Health care costs have risen, on average, 8 percent per year since 1980, while overall rates of inflation have averaged 6 percent. Escalating health care costs

Figure 7.

HEALTH CARE COSTS FOR POPULATION AGE 65 AND OLDER, BY SOURCE OF PAYMENT: 1988



SOURCE: Health Care Financing Administration.

have put a strain on both public and private insurance programs and could create a large gap between Medicare revenues and expenditures even before the year 2000 if current patterns persist.

Yet, a largely unaddressed challenge is how to finance long-term care costs. Recent public sector efforts to expand Medicare's coverage of nursing home costs failed with the repeal of the Medicare Catastrophic Coverage Act of 1988. New efforts focus on passage of tax credits for families that provide dependent care. But many analysts believe that more can be done to encourage private sector initiatives, particularly in the development of home equity conversion plans and long-term care insurance.

Economists estimate that older people have claim to over $700 billion in home equity that could provide a stream of income to cover their long-term care needs. Home equity demonstration projects, however, have shown limited success in attracting older individuals to the program. Furthermore, with homeownership rates of today's young adults below the levels attained a generation ago, home equity conversion may be a less promising option for the 21st century than it is today.

Long-term care insurance is still in its infancy, but for now, it is relatively expensive, limited in coverage, and primarily focused on nursing home care. Affordability is a key barrier. Premiums on a basic long-term care policy for a person age 65 are roughly $1,200 per year. Rates increase as the age of the enrollee increases. At current prices, economists estimate that between 60 and 90 percent of today's elderly could not afford long-term care insurance. Costs could be lowered by selling policies to younger individuals, perhaps as part of an employee benefit package, but persons below age 65 tend to regard the need for long-term care as a remote and unlikely possibility. While the public and private sectors need to coordinate their efforts in developing financial mechanisms to cover the costs of long-term care, individuals and families need to understand the risks and expenses associated with nursing homes and other long-term care arrangements.

FRAMING THE DEBATE FOR THE 1990s

America's social and economic support systems are undergoing evolutionary change. Demographic changes are altering the size and structure of families, the number and characteristics of people in poverty, and the geographic location of people in need. Economic changes are raising questions about the affordability of support programs and the locus of responsibility for providing support.

During the 1990s, policy makers will continue to face an avalanche of competing demands for social services. Many of these demands – for example, pregnancy counseling and parenting programs for teens, child care services for working parents, job training programs for workers and the unemployed, long-term care for the aged, disabled, and terminally ill – will rest on underlying currents of demographic change. While it will take the wisdom of Solomon to weigh and assess the proper system and balance of supports to help people in need, the policy debates of the 1990s are likely to be framed around three central themes: equity, access and affordability, and social-ethical values.

- **Equity.** The aging of the population and the shifting geographic distribution of the population from cities to suburbs, from rural to urban areas, from frostbelt to sunbelt states raise important issues of fairness and equity in the design of our social welfare policies. Indeed, it is demographic changes such as new family patterns, longer life expectancy, and population mobility that are creating the need to reevaluate and, where necessary, redesign our social and economic support systems. The political struggle

A better understanding of the mutual supports and interdependencies between generations will be an important part of policy making in the years ahead.

over the allocation of scarce resources will almost inevitably be seen in terms of generational or regional conflicts and trade-offs. But the key challenge will be to recognize the interdependencies and preserve the supportive bonds that exist between generations and geographic regions.

- **Access and Affordability.** Escalating costs and fiscal constraints will also frame the public debates on welfare reform, social supports, and economic well-being. The price of helping those in need can be high, but so too is the price of neglect. For most individuals and families in the U.S., social and economic change over the past 30 years has raised their standard of living and affords them increased opportunity for individual

growth and personal freedom. For others, however, life's chances too often appear bleak, overwhelming, and without hope. Growing income disparities between rich and poor, the growth of a persistently poor underclass, the presence of homelessness, and the risks of impoverishment from a medical emergency or unforeseen crisis are reminders of the delicate balance that life's circumstances can bring. Leveling the playing field and providing wider access to the opportunities available to most Americans will be an important part of the policy debates in the coming decade.

- **Social and Ethical Values.** While cost constraints may drive a major portion of future policy discussion, social and ethical values will underpin the structure of our support systems. Important legal and ethical issues are already being debated: the right to choose an abortion, the right to protect an unborn life, the determination of mental competency or of informed consent, the right to refuse medical treatment, the right to live, the right to die. Medical science and technological advances are changing human life. How we respond to such challenges is likely to be found in the legal briefs of the coming decades, as well as in our legislative bills. The choices will not be easy, but the increasing cultural diversity of American society will mean that many views and values must be heard.

Demographic change of the past century has set the stage for the one that lies ahead. Increasing numbers of older people, growing racial and ethnic diversity, and changing family patterns will present new challenges for the support systems of American society. Will these demographic changes strain and eventually unravel the patchwork systems that currently help people in need? Or, will we use our knowledge of demographic trends to strengthen the social and economic well-being of all Americans, both now and in the 21st century?

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STATE DATA TABLE

	POPULATION		CHILDREN AT RISK			
	1989 (in 1000s)	% CHANGE 1989-2010	% POPULATION <18/65+ 2010	% OF BIRTHS LOW WEIGHT[a] 1988	INFANT MORTALITY 1988 (per 1000)	% OF ALL BIRTHS TO TEENS 1988
United States	248,239	14	22/14	7	10	13
Alabama	4,118	12	23/14	8	12	18
Alaska	527	45	27/5	5	12	9
Arizona	3,556	50	23/16	6	10	14
Arkansas	2,406	9	22/17	8	11	19
California	29,063	29	23/12	6	9	11
Colorado	3,317	24	22/12	8	10	11
Connecticut	3,239	9	20/15	7	9	9
Delaware	673	17	22/14	7	12	13
District of Columbia	604	11	16/13	14	23	18
Florida	12,671	38	19/21	8	11	14
Georgia	6,436	41	23/12	8	13	17
Hawaii	1,112	40	20/14	7	7	9
Idaho	1,014	6	25/13	5	9	12
Illinois	11,658	− 1	23/13	8	11	13
Indiana	5,593	− 3	23/14	7	11	14
Iowa	2,840	−16	22/16	5	9	9
Kansas	2,513	2	23/15	6	8	11
Kentucky	3,727	0	22/14	7	11	17
Louisiana	4,382	4	25/13	9	11	17
Maine	1,222	7	22/14	5	8	11
Maryland	4,694	21	21/13	8	11	11
Massachusetts	5,913	6	20/14	6	8	8
Michigan	9,273	− 2	23/13	7	11	13
Minnesota	4,353	5	23/14	5	8	7
Mississippi	2,621	16	25/14	9	12	21
Missouri	5,159	7	22/15	7	10	14
Montana	806	− 1	23/14	6	9	10
Nebraska	1,611	− 5	23/15	6	9	9
Nevada	1,111	34	19/12	8	8	13
New Hampshire	1,107	31	22/12	5	8	8
New Jersey	7,736	16	22/14	7	10	9
New Mexico	1,528	47	26/11	7	10	16
New York	17,950	1	21/14	8	11	9
North Carolina	6,571	24	21/15	8	13	16
North Dakota	660	− 7	23/14	5	11	8
Ohio	10,907	− 5	23/14	7	10	14
Oklahoma	3,224	9	23/14	7	9	16
Oregon	2,820	6	21/14	5	9	11
Pennsylvania	12,040	− 8	20/16	7	10	11
Rhode Island	998	9	20/14	6	8	10
South Carolina	3,512	20	22/13	9	12	17
South Dakota	715	1	25/14	5	10	11
Tennessee	4,940	11	20/15	8	11	17
Texas	16,991	31	24/12	7	9	15
Utah	1,707	27	34/9	6	8	9
Vermont	567	7	23/13	5	7	9
Virginia	6,098	22	21/13	7	10	11
Washington	4,761	11	21/13	5	9	11
West Virginia	1,857	−13	21/16	6	9	17
Wisconsin	4,867	− 3	23/15	5	8	10
Wyoming	475	3	26/10	7	9	12

[a] Low birth weight is less than 5.5 pounds.
[b] Average monthly benefit for a single mother with two children.
[c] Average monthly benefit for a retired worker.
[d] Includes Medicare's Health Insurance and Supplemental Medical Insurance programs.

NA – Not Applicable; Arizona does not have a federal Medicaid program.

SOURCES:

Population – U.S. Bureau of the Census, Series P-25, No. 1058 and No. 1017;
Low Birth Weight, Infant Mortality, and Teen Births – National Center for Health Statistics, *Monthly Vital Statistics Reports* and unpublished data;
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Health Insurance – PRB analysis of Census Bureau CPS March Supplement tapes, 1988-1990;
Medicare and Medicaid – Health Care Financing Administration, Medicaid Statistics Division and Bureau of Data Management, unpublished data.

INCOME MEASURES				HEALTH MEASURES			
PER CAPITA PERSONAL INCOME 1989	% IN POVERTY <18/65+ 1985-1989	AVERAGE MONTHLY AFDC PAYMENT[b] 1989	AVERAGE MONTHLY SOCIAL SECURITY BENEFIT[c] 1989	% NONELDERLY WITHOUT HEALTH INSURANCE 1989	MEDICARE[d] PAYMENT PER RECIPIENT 1989	MEDICAID PAYMENT PER RECIPIENT 1989	
$17,567	20/12	$381	$567	17	$2,852	$2,318	U.S.
13,679	31/21	114	521	21	2,230	1,586	AL
21,173	14/9	616	570	21	3,087	3,444	AK
15,881	20/8	271	574	22	2,752	NA	AZ
12,984	29/23	193	506	24	2,466	2,029	AR
19,740	21/6	611	579	22	3,060	1,653	CA
17,494	18/12	323	555	17	2,280	2,366	CO
24,604	8/8	527	622	10	2,851	4,504	CT
19,116	15/13	280	590	15	2,733	2,895	DE
23,436	28/16	356	486	23	4,872	2,490	DC
17,694	20/11	249	567	23	2,977	2,183	FL
16,188	24/18	260	524	18	2,782	2,107	GA
18,306	17/10	535	559	12	1,918	1,710	HI
13,762	19/10	248	551	20	2,233	2,851	ID
18,858	22/11	317	604	13	2,989	2,016	IL
16,005	17/10	262	591	16	2,518	3,708	IN
15,524	18/10	357	569	10	2,312	2,320	IA
16,182	14/12	345	579	13	2,423	2,147	KS
13,777	22/21	221	518	18	2,658	1,879	KY
13,041	32/24	167	526	24	3,220	1,970	LA
16,310	16/14	400	522	12	2,500	3,016	ME
21,020	14/10	350	566	12	3,549	2,916	MD
22,196	14/9	562	570	11	3,014	4,112	MA
17,745	20/9	482	605	11	3,257	1,749	MI
17,746	18/9	524	552	11	1,819	3,421	MN
11,835	34/29	118	486	24	2,584	1,167	MS
16,431	19/14	269	554	14	2,743	1,924	MO
13,852	22/12	362	555	19	2,374	2,541	MT
15,360	18/12	332	562	14	2,068	2,349	NE
18,827	15/8	277	569	21	2,779	2,561	NV
20,251	6/9	413	570	15	2,224	5,083	NH
23,764	13/9	358	620	12	3,077	3,602	NJ
13,191	28/18	225	536	27	2,295	2,080	NM
20,540	23/13	532	606	15	3,321	4,523	NY
15,221	18/21	238	526	18	2,286	2,392	NC
13,261	16/13	365	534	11	2,500	3,787	ND
16,499	19/9	310	581	12	2,958	2,351	OH
14,151	22/15	288	541	24	2,678	2,510	OK
15,785	16/11	358	578	18	1,976	1,920	OR
17,422	16/10	352	585	11	3,331	2,233	PA
18,061	12/10	476	566	11	2,191	3,631	RI
13,616	22/21	203	526	17	1,998	2,007	SC
13,244	20/15	272	524	16	2,147	3,178	SD
14,765	26/21	168	526	17	2,737	1,790	TN
15,483	24/17	169	549	27	2,875	1,878	TX
13,027	12/7	353	577	13	2,364	2,138	UT
16,399	13/10	492	553	12	2,274	2,509	VT
18,970	16/12	260	532	14	2,677	2,383	VA
17,640	16/6	449	588	15	2,490	2,253	WA
12,529	28/16	254	561	17	2,378	1,350	WV
16,759	13/8	462	582	11	2,469	2,784	WI
14,135	15/9	306	567	16	2,580	1,774	WY

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